

"Planning our Response to HIV/AIDS"



**A STEP BY STEP
GUIDE TO
HIV/AIDS
PLANNING FOR
THE ANGLICAN
COMMUNION**



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A joint project of

The Council of Anglican Provinces in Africa
The POLICY Project (South Africa)
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BACKGROUND:

All Africa Anglican Conference, 13-16 August 2001, South Africa
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At the invitation of the Most Reverend Njongonkulu W.H. Ndungane, Archbishop of Cape Town, Metropolitan of the Church of the Province of Southern Africa, the first All Africa Anglican HIV/AIDS Conference brought together over 100 delegates from all nations in the sub-Saharan Africa region as well as representatives from international organisations across the globe.

The main objective of the Conference was to engage the Anglican Communion in a process of strategic planning to guide its response to HIV/AIDS in sub-Saharan Africa. The conference also aimed to provide delegates with a model of planning that they could adapt and use at a parish, diocese, or provincial level.

The Conference followed two distinct tracks:

- Track One - Anglican Communion representatives:

Delegates participating in this track included representatives from all levels of the Anglican communion, across all the church provinces of sub-Saharan Africa, and included a delegation of people living with HIV/AIDS from a number of African countries. Delegates participated in four sessions which focused on their own experiences of the HIV pandemic at a local level, the vision they have about key issues facing their church communities in relation to HIV/AIDS, and how they believe the worldwide Anglican Communion can best intervene in and contribute to the unfolding pandemic.

- Track Two - Partner Organisation representatives:

Delegates participating in this track included representatives from international donor agencies, AIDS service organisations, civil society groups and government departments. Delegates participated in four sessions which focused on their own experiences of the HIV pandemic at a local level, the vision they have about key issues facing their church communities in relation to HIV/AIDS, and how they believe the worldwide Anglican Communion can best intervene in and contribute to the unfolding pandemic.

Working with the Anglican Communion, the POLICY Project (South Africa) designed a planning model to enable participants – through the course of the All Africa Conference – to both contribute to the development of an integrated strategic plan for the HIV/AIDS Provinces of sub-Saharan Africa of the Anglican Communion, and to become familiar with a step by step planning approach which could be adapted for use by a province at a local level – diocesan and parochial.

As an outcome of this process, delegates produced a framework ("Our Vision, Our Hope, The First Step": All Africa Anglican AIDS Planning Framework) which will now be used to guide the Anglican Communion in their local HIV/AIDS planning. This framework is found on the next page.

OUR VISION, OUR HOPE THE FIRST STEP

ALL AFRICA ANGLICAN AIDS PLANNING FRAMEWORK

AUGUST 2001
JOHANNESBURG

1. Vision

We, the Anglican Communion across Africa, pledge ourselves to the promise that future generations will be born and live in a world free from AIDS.

2. God's call to transformation

We are living with AIDS. As the body of Christ, confronted by a disaster unprecedented in human history, we share the pain of all who suffer as a result of AIDS. Faced by this crisis, we hear God's call to be transformed. We confess our sins of judgement, ignorance, silence, indifference and denial.

Repenting of our sin, we commit ourselves to:

- ☐ Breaking the silence in order to end all new infections
- ☐ Educating ourselves at every level within the Church
- ☐ Confronting poverty, conflict and gender inequalities
- ☐ Ending stigma and judgement, and
- ☐ Holding ourselves accountable before God and the world.

Only then can we live out the Good News of the all-embracing love of Christ.

3. Our mission

Our mission is to respect the dignity of all people by:

- ☐ Securing the human rights of those infected by HIV/AIDS, and giving unconditional support
- ☐ Improving the health and prolonging the lives of infected people
- ☐ Accompanying the dying, those who mourn and those who live on
- ☐ Celebrating life
- ☐ Nurturing community, and
- ☐ Advocating for justice.

We acknowledge that we cannot do this alone. We are sustained by the love of God and emboldened by the Holy Spirit. We are inspired by the compassionate efforts of the faithful in attending to those affected by HIV/AIDS. We accept the responsibility of our leadership. We invite the wider community into creative, life-giving partnership.

4. Our commission in the context of AIDS

We believe we are created, in the image of God, as physical and spiritual beings. We are created to be in relationship to God, the community and ourselves. We believe that we are given the freedom to make choices, to love, to celebrate, to live in dignity and to delight in God's creation. We believe that suffering and death are neither punishment from God nor the end of life and that we are called to an eternal union with God.

Stigma is a denial that we are created in the image of God. It destroys self-esteem, decimates families, disrupts communities and annihilates hope for future generations. We commit in all our efforts - personal and corporate, programmatic and liturgical - to confront it as sin and work for its end.

Given who we are, and who we are called to be by God, we have defined and embraced a six-fold commission of ministry in response to AIDS.

These six calls in our commission are:

4.1 Prevention

The Church's commitment to prevention recognises that all life is sacred. Because we love our children, we speak and act to protect them from infection. Sex is a gift from God. We are accountable to God and one another for our sexual behaviour. Christian communities have a special responsibility and capacity for encouraging and supporting loving, just, honest relationships.

4.2 Pastoral Care

Pastoral care supports spiritual growth with the aim of sustaining whole and holy relationships with God, each other and community. This is achieved by affirming the dignity and worth of each human being and making clear the claim of God in our lives.

4.3 Counselling

Christian counselling equips people to live into God's invitation to wholeness, freed of the burdens of the past, and capable of moving in freedom toward the perfection promised in Christ's example with confidence and determination.

4.4 Care

In caring for all who suffer, we fulfill God's purpose by restoring dignity and purpose to people's lives. Christian care, therefore, seeks the fullness of life, in the context of the community, by the restoration of body, mind and spirit.

4.5 Death and dying

Death is a rite of passage in our spiritual journey and into eternal life. The call of all Christians is to uphold the dying by our love, as well as those who live on and those who mourn. While death brings suffering and loss, our faith can make it a time of enhanced relationship and growth for individuals and communities. We are a resurrection people and our relationship with God does not end with the death of physical bodies.

4.6 Leadership

All authority is accountable before God. All people of the church are stewards of God's creation. We have a unique responsibility to speak truth to power, to act without fear, and to embody Christian values of love, compassion and justice.

5. Our Response

5.1 Prevention

Out of love for our children, one another and our communities, we commit to speak openly and with moral authority about responsible sexual behaviour, and to support one another, embracing and adopting behaviours that avoid the transmission of HIV.

5.2 Pastoral Care

As the embodiment of the merciful Christ in a suffering world, we commit to equip our clergy and laity to support all people, especially those living with HIV, in life-sustaining relationships with their God and their community.

5.3 Counselling

We commit to promote voluntary counselling and testing for HIV by our own examples and as a ministry of the Church. We call for the establishment of support groups and other counselling services for those who are orphaned, ill, afraid, dying or bereaved.

5.4 HIV Care

We commit to being central to networks of community support, to meet the health care and basic needs of those who are orphaned, ill or excluded due to HIV, freeing them to productive life as long as their health permits.

5.5 Death and Dying

As death transforms the body, AIDS calls us to transform those traditions and practices, by which we care for the dying and honor our dead, that consume scarce resources and contribute to denial.

We commit to:

- ❑ Training the Church to provide holistic care for the dying and prepare families for living on
- ❑ Offering rituals that honor the dead and promote the well-being of those who survive
- ❑ Training the clergy to counsel and protect the rights of those who survive, especially women and children.

5.6 Leadership

Silence permits inaction and is the breeding ground of stigma. We call for bold, compassionate community and institutional leadership at every level, to prevent infection and care for the ill and dying. We invite similar leadership by government, and all sections of society and international partners. Because leadership must address power, culture and morality, we call on our government leaders to be accountable for health expenditures and to declare an 'HIV state of emergency', in order to combat AIDS and mobilise resources. We further declare that all people have the right to health, which includes access to basic health care. HIV calls for bold and creative approaches by our leaders, which recognizes the reality of power and gender patterns at community levels, and mobilize resources and facilitate development of new models of leadership, particularly among laity and women.

5.7 Education and training

Nothing in our educational systems equips us to deal with this catastrophe. In achieving the strategies outlined in this document, it is essential to assess needs and establish education and training capacity, in order to assure that sufficient numbers of clergy and laity:

- ❑ Have current and accurate basic information on the science of HIV, standards of home-based care, and the rudiments of treatment.
- ❑ Have both the technical information and the interpersonal communication skills to effectively teach and counsel regarding human sexuality.
- ❑ Are knowledgeable of local laws and practices regarding inheritance and equipped to impart that information.
- ❑ Receive practical training in community organisation and development, so that they may assist in establishing care and support which is needed.
- ❑ Are trained and available to meet exploding demands for pastoral care necessitated by HIV/AIDS

5.8 Theological reflection

As the Church, it is uniquely our task to gather for study, for prayer and for worship. Therefore we must engage in constant theological reflection, seeking discernment on the issues of sin, guilt, grace, judgement and forgiveness. To this we commit ourselves, our families and our friends.

Amen!

INTRODUCTION TO THE PLANNING PROCESS

Following the success of the All Africa Anglican Conference the challenge now lies in taking this planning process into each province, so as to pave the way for a comprehensive, integrated and holistic response to the pandemic by Anglican church communities across the continent.

To this end, the current manual as been designed to assist church communities to embark upon their own HIV/AIDS planning. It is hoped that the step by step planning model outlined in this manual will provide an accessible planning framework to support the ongoing HIV/AIDS activities of Anglican communities.

The planning model that is used has been designed in such a way as to enable members of the Anglican community to contribute to the development of **an integrated strategic plan** for the Anglican Communion in sub-Saharan Africa and **engage in a planning process** to meet the challenges posed by the impact of HIV within their local context. A facilitator's guide to the planning process is provided for this purpose.

The aims of the planning process are:

✚ To facilitate discussion on the **experiences** of church communities in the context of HIV/AIDS.

✚ To determine how these communities can **plan** to best intervene in meeting the challenges of this pandemic.

The tools and step by step approach to HIV/AIDS planning are designed for use in a group planning situation. Participants should represent the local church community. The sharing of ideas and contributions from **all levels** of the church structure is vital to the success of this planning process. Together, the group will engage in a 5 step participative planning process. Each step in the planning process outlined in this manual is participation-driven.

HIV/AIDS planning process

A step by step guide
to HIV/AIDS planning
for the Anglican
Communion

Step 1

Situational analysis

Step 2

Identifying
issues,
solutions &
options

Step 3

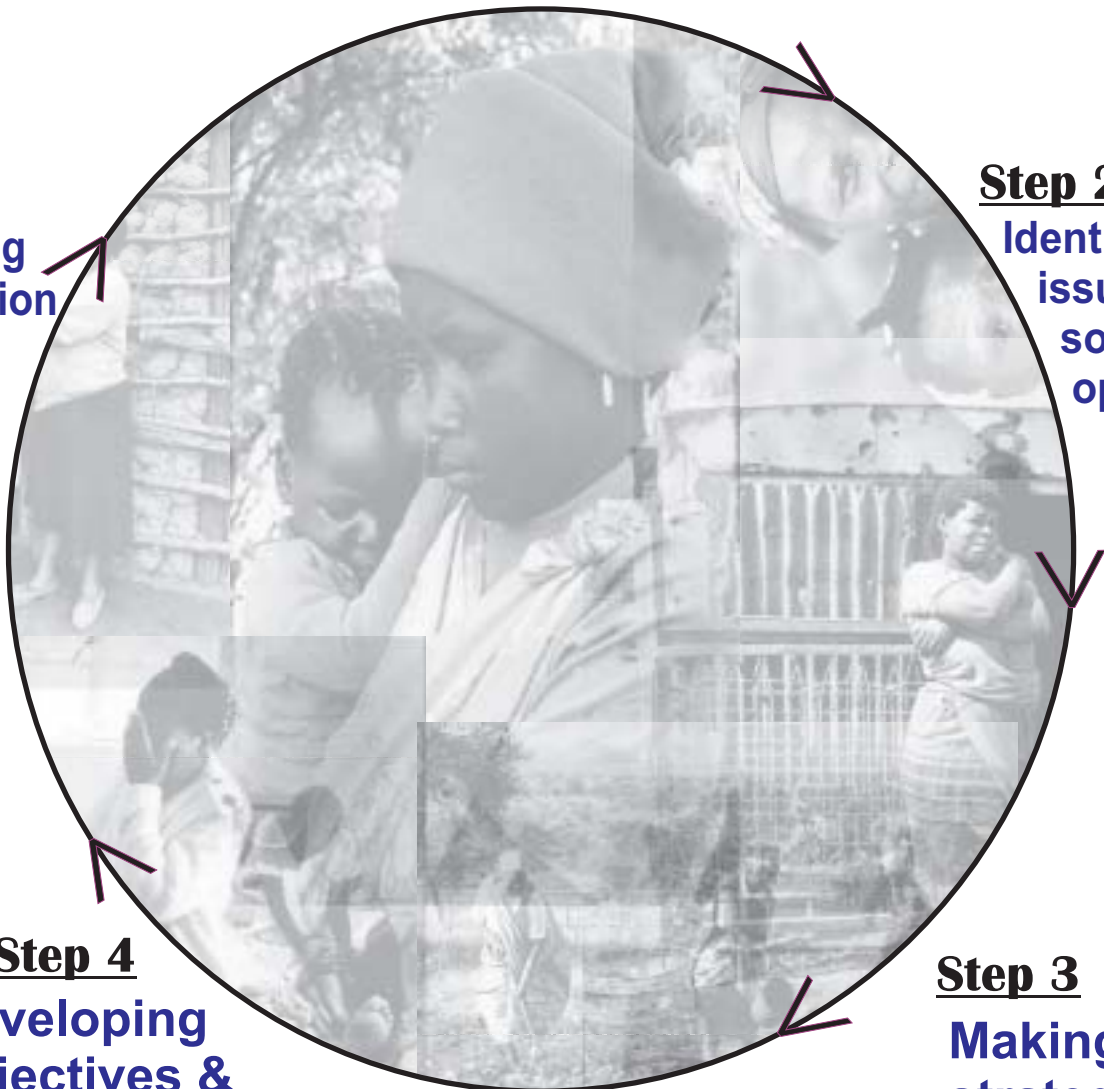
Making
strategic
choices

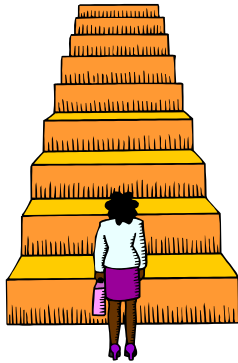
Step 4

Developing
objectives &
activities

Step 5

Monitoring
& evaluation





SUMMARY OF THE 5 STEP PLANNING MODEL

STEP 1 A SITUATIONAL ANALYSIS



This step lays the foundation for the planning process and considers **what we know** and have witnessed about the HIV pandemic within the church and broader community.

The focus is on **sharing** and **documenting models** of current (and best) practice in the church. This will create a clearer understanding of the local HIV/AIDS context.

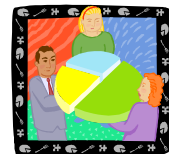
STEP 2 IDENTIFYING ISSUES, SOLUTIONS & OPTIONS



This step has three parts.

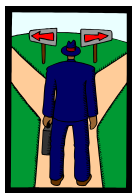
Firstly we need to consider how the specific issues that a given community are facing, in the context of HIV/AIDS, **are understood** and are **inter-related**.

Secondly we explore how these issues **impact** on the broader community.



Thirdly, a framework (in the form of a **solutions chart**) is provided through which participants can explore the range of possible ways in which the church can intervene to support those infected and affected by HIV/AIDS.

STEP 3 MAKING STRATEGIC CHOICES



This stage of the planning approach involves applying **strategic thinking** to the decisions about which course of action should be taken by the church in the local context.

Here the various courses of action that were identified by the group in Step 2, are weighed against each other. **Decisions** are then made about which represents the most appropriate area for future church HIV/AIDS activities.

STEP 4 DEVELOPING OBJECTIVES AND ACTIVITIES



This section enables us to develop **objectives** and activities to guide the church's future HIV/AIDS programmes or interventions.

Consideration is given to specific responsibilities that both the church leadership and laity ought to assume in the implementation of their future HIV/AIDS programmes.

STEP 5 MONITORING AND EVALUATION



This section reflects on the role of **monitoring** and **evaluation** in the planning process. Here we need to consider how we might begin to measure the impact of proposed HIV/AIDS interventions, monitor their progress and determine what particular aspects of the programme were successful or not.

HOW THIS MANUAL WORKS

The interactive approach to planning outlined in this manual aims to provide simple tools to assist you, the facilitator, in the process of formulating realistic and context specific plans to guide the future HIV/AIDS work within your Anglican community.

The manual is divided into an introductory session, followed by 5 sections - each corresponding to a step in the planning process. Each section includes a set of activities and accompanying resources that can be used as planning tools for adaptation to the local context.



Introductory session



Section one: A situational analysis



Section two: Identifying issues, solutions & options



Section three: Making strategic choices



Section four: Developing objectives and activities



Section five: Monitoring and evaluation

Each section is divided into the following categories:



OUTCOMES

These are the intended results i.e. what we will have achieved, once the activities in this section are completed.



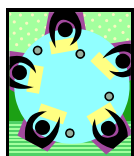
RESOURCES

A list of the material resources you will need for the group activities as well as the worksheets and prompt sheets that are provided to assist you in facilitating the section. These are contained in the Appendix section of this manual.



TIME

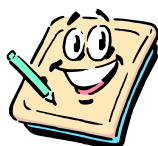
The approximate time that would be needed for each section is indicated. The time may vary according to group size, needs and energy of the group.



METHOD

This is a step by step guideline of how the planning model can be put into practise. This includes:

- small group activities
- exercises using worksheets and prompt sheets
- tips on facilitation techniques



TALKING NOTES

The talking notes serve to help you with questions and information that you need to put to the participants to stimulate discussion and explain concepts.



SUMMARY

A brief summary is essential at the end of each section. This helps participants to keep track of what they are doing.

Introductory session





INTRODUCTORY SESSION

The planning sessions should ideally involve a maximum of 30 participants. The group should include wide representation across all church levels and structures.

Before embarking on the planning process, it is a good idea to welcome your group to the planning process and inform them about the way in which the planning sessions will be conducted. This section of the manual provides an outline of how you might want to facilitate the introductory session of the planning process.



OUTCOMES

- To introduce participants to each other, and reach consensus on the ground rules for the planning process.
- To share both the participants' expectations and the objectives of the planning session. This helps everyone to understand and be clear about the planning process and the goals the group is working towards.
- To introduce the 5 step planning model.



RESOURCES

Nametags

Koki's and pens

Prestick

Appendix 1, worksheet 2

Flipchart paper

Crayons

Appendix 1, worksheet 1

Appendix 3A and 3B



TIME

1 hour



METHOD

ACTIVITY 1

WELCOME AND INTRODUCTIONS



Make sure that each participant has a nametag. Introduce yourself and welcome participants to the planning sessions.

Participants stand in a circle and introduce themselves to the group, stating their name and the church structure they represent.

Divide participants into small groups of 4/5 persons per group for the purpose of the small group activities that run throughout the planning process.



For tips on how to divide participants into groups see Appendix 3A.

ACTIVITY 2

SETTING GROUND RULES



It is useful to get the participants to agree on the rules that will govern your time together. You may want to write these **ground rules** on flipchart paper and display in a visible place. This helps to remind the group of these rules throughout the planning session.

A few common ground rules could be:

- ✓ cell phones to remain off for the duration of the planning session
- ✓ keep to the time schedule
- ✓ promote full participation
- ✓ give other participants a chance to speak
- ✓ respect the confidentiality of the group.

ACTIVITY 3

PARTICIPANT EXPECTATIONS AND WORKSHOP OBJECTIVES

It is a good idea to create an opportunity for participants to share their expectations of the planning sessions with you and the bigger group. Ask participants to work in their small groups and share their expectations with other group members.

Take feedback from each group in plenary and write up on flipchart.



For tips on how to get participants to share expectations see Appendix 3B.



You will then need to present the **broad objectives** of the planning session, such as:

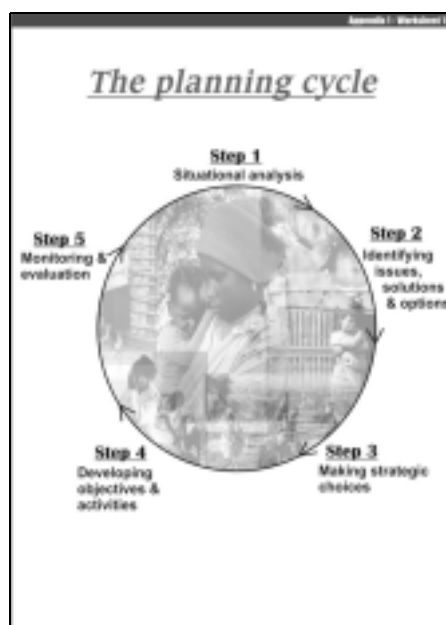
- ⚡ Why we are here
- ⚡ What we hope to achieve
- ⚡ How the planning process will work

(You will find this information on page 9)

It is useful to refer to the participants' expectations at this stage. See which expectations you can realistically aim to meet and which of those fall outside the scope of the planning sessions.

ACTIVITY 4

Using the worksheet and the explanation on pages 10-11 as a guide, you now need to introduce the 5 step planning cycle to the group. Briefly outline each step and what it broadly aims to do.



Appendix 1: worksheet 1

The introductory session is now complete.

Situational analysis





STEP 1: A SITUATIONAL ANALYSIS



OUTCOMES

- To understand the meaning and function of a situational analysis.
- To conduct a brief situational analysis of HIV/AIDS in a local context.
- To explore the level and extent of current HIV/AIDS involvement in the church and capture examples of best practise.
- To identify the gaps and opportunities that exist in the local community that will inform the church's future HIV/AIDS planning.



RESOURCES

Flipchart paper

Prestick

Kokis and pens

Crayons (a set of 3 different colours for each small group)

Appendix 2, prompt sheet 1

(make a photocopy for each participant)

Appendix 1, worksheet 2

(make a photocopy for each participant)

Appendix 1, worksheet 3

(make a photocopy for each participant)

Appendix 1, worksheet 4

(make a photocopy for each participant)



TIME

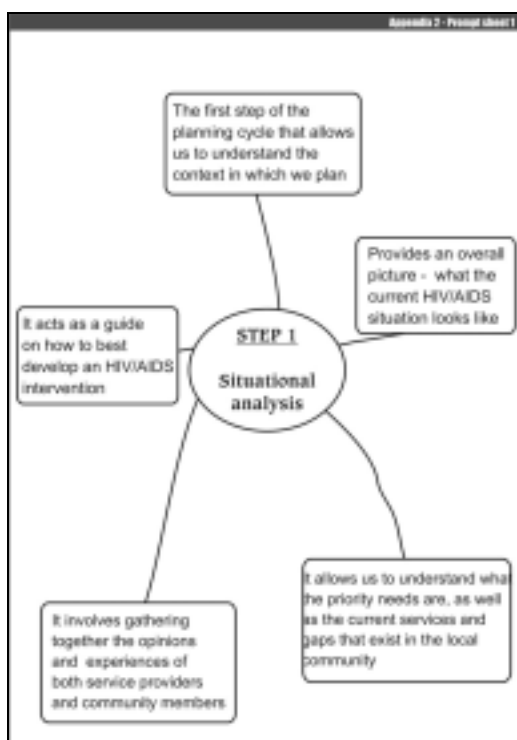
3 hours



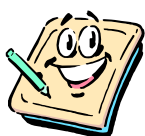
METHOD

ACTIVITY 1

Use the prompt sheet and the text below to introduce to the group the role and function of situational analyses in the planning process to the group:



Appendix 2: prompt sheet 1



A situational analysis forms the first part of the planning cycle and answers the question *where are we now?*

It is an activity that **describes** and **analyses** what is happening on the ground.

A team or a group of individuals generally undertakes a situational analysis.

It is done in order to determine:

what the **priority needs** are of a particular community,
what services or facilities they currently have access to – or do not have access to – and
what some of the gaps are (in terms of services, resources and skills) that exist in the community.



In the course of conducting a situational analysis, people's opinions, perceptions and experiences are gathered together – along with relevant 'facts' and statistics.

By identifying and highlighting priority problems, a situation analysis can be used as a guide to show how best one 'ought to work' – alongside a community – in seeking solutions to some of the key problems that the community is experiencing.

ACTIVITY 2

Give each participant a copy of the worksheet. In small groups they have to explore the specific issues that HIV/AIDS raises in their community, as well as the impact it is having on both an individual and a collective level.

Appendix 1: worksheet 2

Small groups address the questions on the worksheet and one person in the group is given the task of recording the group's discussions on flipchart.

Small groups report back to plenary.



ACTIVITY 3

Having determined the issues and some of the ways in which HIV/AIDS is being experienced in your community, the aim is now to assess the **level** and **extent** of the current HIV/AIDS involvement of the church.

You need to ask this question:



What is the extent of your church's involvement in HIV/AIDS?

Using the worksheet below, ask individuals to list all the HIV/AIDS activities their church is currently involved in. They need to group these activities under the topic areas on the worksheet, namely: care and support; community outreach; training and prevention. The group may wish to add additional categories where applicable.

Appendix 1: worksheet 3

Once the participants have listed all their church's HIV/AIDS related activities, you need to ask them:



At what level are these programmes taking place i.e. parish, diocesan or provincial?

Ask the participants to use 3 different colour crayons, each representing a different level in the church. For example:

Orange = parish level

Red = diocesan level

Green = provincial level

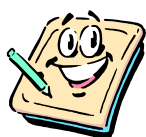


Participants now show the different levels at which their church is involved with HIV/AIDS by circling the appropriate activities in the colours they have chosen for each church level.

Participants share their drawing with their small group members and display them on the wall. These will be reflected on in Activity 4.

ACTIVITY 4

You need to introduce the concept of **best practice**, using the text below as a guide.



'Best Practice' refers to the continuous process of learning, feedback, reflection and analysis of what works and why. It is the basis from which we can identify, exchange and document important lessons learned in our HIV/AIDS work. There are wonderful examples - in our provinces, diocese and parishes - of HIV/AIDS best practices. Sharing these exemplary models will help us to learn from each other, and strengthen programme planning. The situational analysis provides an opportunity to identify examples of 'best practise' that exist within your church community.

You have to ask the participants:



What would you say is the most powerful aspect of your church's involvement in HIV/AIDS?

Get the participants to sit in a circle in the big group. Give each participant the opportunity to share, in a few sentences, the most powerful aspect of their churches involvement in HIV/AIDS. Participants may want to reflect on the drawings in Activity 3 in answering this question.

Hand out copies of the worksheet to the group and explain that it is aimed at identifying model examples of the church's HIV/AIDS response in the local context. Get the participants to complete questions 2 and 3 in their own time. Collect these completed worksheets from the participants, for future reference.

Worksheet 1 - Worksheet 1

Learning from each other

What Worksheet is the continuous process of learning, feedback, reflection and analysis of what works (or does not work) and why. It is the basis from which we can identify, exchange and document important lessons learned in our HIV/AIDS work.

There are wonderful examples in our provinces, districts and parishes - of HIV/AIDS best practices. Sharing these examples enables us to learn from each other, and strengthen both our own programmes and the response of the Anglican communion as a whole to the HIV/AIDS pandemic.

1. Does your church or neighbouring church have a specific HIV/AIDS programme that you think could serve as a benchmark model for other churches in the Anglican communion?
2. Describe this programme so what does it do and how does it work?
3. Why do you think that this programme could serve as a good model of practice?
4. Who are the programme leaders and who is it managed by?

YOUR NAME:
YOUR CONTACT NUMBER:

Appendix 1: worksheet 4

ACTIVITY 5

A critical element to situational analyses is identifying **the gaps and opportunities** that exist in our current HIV/AIDS work. We need to explore how we can start filling these gaps and meeting such challenges in our future HIV/AIDS programme planning.

Run a plenary session guided by the following questions:



- ⦿ What else do we **need to do** as the Anglican community in terms of HIV/AIDS activities?
- ⦿ Given our strengths as a church community, what opportunities exist for us **to improve** on our current HIV/AIDS activities?

Write the responses on flipchart paper or get a participant to write the responses up.



Important: you need to summarise the session.



Emphasise how the 'situational analysis' forms the foundation for the planning process by describing 'what is' i.e. the **current HIV/AIDS situation** in the community.

Through the steps of the planning process that follow, the group will be considering what needs to be done to move towards 'what ought to be' i.e. our vision for the future concerning HIV/AIDS.

The framework of this vision is represented in the Anglican Communion's vision statement that you now read to the group (see pages 5-8 for "Our Vision, Our Hope, The First Step": All Africa Anglican AIDS Planning Framework).

Identifying issues, solutions
and options





STEP TWO: IDENTIFYING ISSUES, SOLUTIONS AND OPTIONS



OUTCOMES

- To identify the key issues we face in relation to HIV/AIDS in the local context.
- To explore possible solutions to these issues, and plot the cause and effect chain that exists amongst these key issues.



RESOURCES

100 coloured cards (50 of one colour and 50 of another)

Appendix 1, worksheet 5 (make a photocopy for each participant)



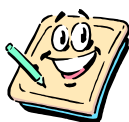
TIME

3 hours



METHOD

Introduce the session using the notes below.



In order to make strategic plans about what we need to do and how we are going to do it, it is necessary to unpack all the issues facing a particular community in the face of HIV/AIDS. After we understand the inter-relation between these issues we will be able to identify solutions around which to build our plans, and then make strategic choices as to how we can best go about fulfilling our objectives.

Give each participant a copy of the worksheet.



Appendix 1, worksheet 5

You need to introduce the six theme areas that were identified by the Anglican communion in sub-Saharan Africa, for the purpose of HIV/AIDS strategic planning.

Explain that the above six themes represent a framework to guide the Anglican church's HIV/AIDS response across Africa. It is a framework designed to assist in the group's planning process. The framework ensures that all areas of HIV/AIDS are given equal attention. It also provides a common framework around which all Anglican communities can structure their HIV/AIDS plans and interventions.

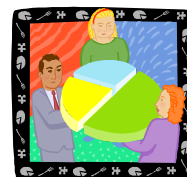
Divide participants into 6 theme groups, as follows:

- Group One: **CARE**
- Group Two: **PREVENTION**
- Group Three: **COUNSELLING**
- Group Four: **DEATH AND DYING**
- Group Five: **PASTORAL CARE**
- Group Six: **LEADERSHIP**

Explain that each group will focus on a specific theme area, which will provide the guiding framework for the activities in the remaining step of the planning process

ACTIVITY 1 – THE PROBLEM ANALYSIS CHART

You need to explain to participants that they are going to follow a structured approach of problem analysis. This will allow the group to visualise the range of HIV/AIDS related problems facing the community, and how these problems interlink with one another. The problem analysis chart is not intended to simplify these problems, rather it helps us to deepen our understanding of them in the local HIV/AIDS context.



Get participants to work in their 6 theme groups.

STEP 1

- Each theme group writes down approximately 10 problem statements. Each problem should be written on a separate card. All the cards must be the same colour. Each card should describe one problem experienced by people in their particular context or community with regard to the group's theme. For example, the theme group dealing with prevention will focus on problems around prevention; the leadership theme group will focus on problems around leadership and so on.

How to write problem statements (see example of problem analysis chart on pages 29-30):

Be as specific and accurate as possible

Do not write 'no' or 'lack of' as this indicates the absence of a solution.

State the problem as a negative condition

STEP 2

- As a starting point, select one **focal problem** for the analysis. Note this is NOT necessarily the core problem or the most important problem. This is rather a statement that people agree provides a *starting point* for building the chart. Write this statement in the middle of the flipchart paper.



STEP 3

- Organise the problem cards on the flipchart paper into those that describe possible **causes** of the focal problem, and those that describe the **effect** or impact of the focal problem. Use the example on page 30 to guide you.

STEP 4

- Add cards if needed so that there are logical links between statements that refer to the causes and those that represent the effects of the focal problem.
- Re-write cards to be more specific and real. Remove cards that are repetitive and make sure the statements are substantial.

STEP 5

- Review the problem analysis chart to ensure that the planning team agrees that the cause-effect relationships are sequential and valid.
- Each theme group should present their problem chart to the bigger group and explain the web of causes and effect relationships that the chart represents.



You need to summarise the problem analysis chart activity, using the notes below to assist you.



The problem analysis chart presents us with a visual image of all the interlinked problems, issues and concerns that our communities experience in the face of HIV/AIDS. We can see that each problem chart illustrates a web of cause and effect relationships. Understanding these complex relationships allows us to think strategically when we plan our HIV/AIDS interventions.

The problem analysis chart allows us to reflect on the *different* aspects of a single problem and illustrates just how much broader the issues are that influence our work. We are then able to identify the specific approach we might want to take in eliminating or reducing the problems that the HIV/AIDS epidemic poses for the community. Each HIV/AIDS intervention, however small, has a role to play in transforming the web of problems we see in the problem chart, into the vision we have of lessening the impact of HIV/AIDS on our communities.

Time for reflection

Spend some time exploring with the group how HIV/AIDS has affected them as individuals. You can draw attention to the links between the issues represented on the problem analysis chart, and how HIV/AIDS has impacted on the participants' own lives and behaviours.



The HIV/AIDS risk checklist in Appendix 3C is a tool for reflection.

Problem Analysis Chart

An example

This problem analysis chart was developed by a group of delegates participating in the theme group that looked at the issue of care at the All African Anglican Conference on HIV/AIDS, held in South Africa, 13th - 16th August 2001. This is an example of how the problem analysis chart exercise can unfold in reality! However, you must remember that if the same theme was given to a different group of people they would have come up with a very different picture of what they thought the focal problems are, and what effect they have on the community.

When the group was asked to write down what they thought were some of the main problems experienced in their community in relation to care, they said the following:

That the **two key problems** (that we suggested were our focal problems) were that the **church was ignorant** about HIV/AIDS, and that it had **failed to 'own' HIV** (ie. to accommodate HIV and to identify with the problem of HIV/AIDS).

As a consequence of this:

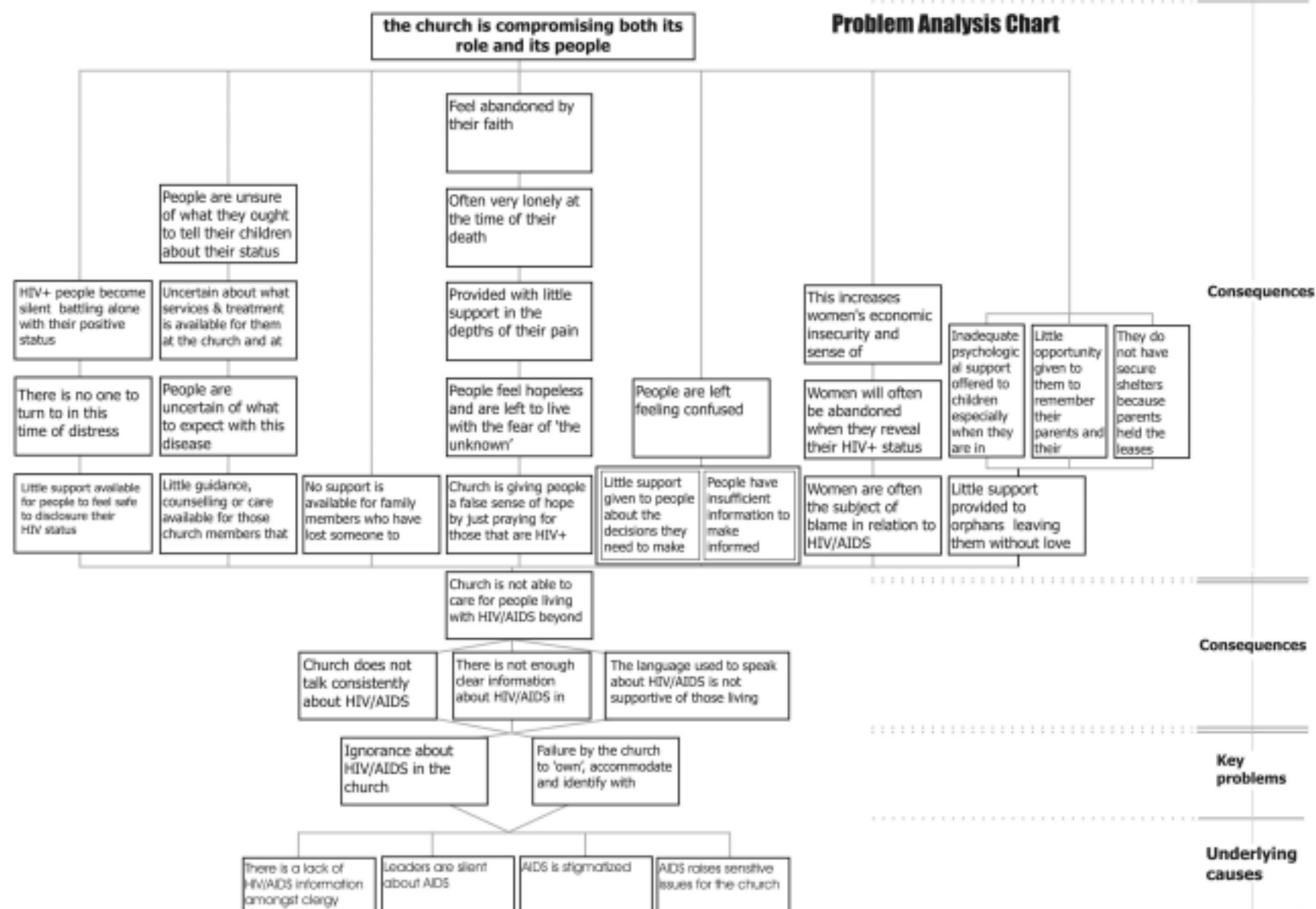
- ✍ the church does not talk consistently about HIV/AIDS;
- ✍ there is not enough clear information about HIV/AIDS (in general and in particular about the care that is needed for those living with HIV/AIDS); and
- ✍ the language that is used to speak about HIV/AIDS is not supportive of those living with HIV.

What this indicated was that the church is not able to care for people living with HIV/AIDS beyond prayers.

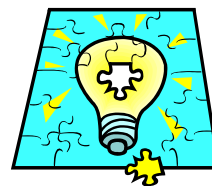
This in turn has various consequences:

- ✍ That the church is giving people a **false sense of hope** (eg. 'we will pray for you and you will be healed'). This leaves people with a feeling of hopelessness and fear of the unknown, and often means that they are provided with little support in the face of their pain, are often very lonely at the time of their death, and feel abandoned by their faith.
- ✍ There is little support for people around **the disclosure of their HIV status**. People feel that there is no one to turn to in this time of uncertainty and distress, and people become silent - battling with their thoughts about their positive status - alone.
- ✍ There is little support given to people when they need to **make decisions in relation to HIV**. People are left feeling confused (having insufficient information to make the choices that they are told they face because there is no one to guide them in their decision-making). These could be decisions about whether or not to have an HIV test, or about deciding to have a baby without knowing whether you are HIV+ or HIV negative, or about making decisions when you are HIV+ about accessing treatment.
- ✍ That there is little guidance, counselling or care available for those that are **living with HIV** from the church. People are thus often uncertain of what to expect, what services are available to them within the communion and within the broader community, what they ought to tell their children about their status; and what treatment is available for them.
- ✍ There is very little protection provided by the church for **women** who are often the subject of blame in relation to HIV/AIDS.
- ✍ That little support is available for **family members** of those that have lost someone to HIV/AIDS.
- ✍ There is little support provided to **orphans** leaving them without love, and parental guidance. Little support is offered to them in their processes of mourning and little opportunity is given to them to remember their parents and their previous homes. Their shelters/homes are often insecure - as they might have been rented by their parents - and thus might very well not be in their possession much longer.

One participant said that because of all of this - the church is thus 'compromising both its role and its people'.



ACTIVITY 3 - THE SOLUTIONS CHART



Introduce the activity.



A solutions chart describes the range of potential improvements that our plans can make to people's lives. It is seldom possible for all these solutions to be implemented by a single programme intervention. However, it alerts us to the range of possible solutions and the relationship between them.

After your introduction, follow these steps:

STEP 1

The theme groups must now restate all the problem statements in their problem analysis chart as positive, desirable and realistic conditions. Write these up on colour cards of a *different* colour to those used on the problem chart. Each problem should be stated as an outcome. This means that they are stated as though they have already occurred. Work from the top of the chart downward (see example of a solutions chart on pages 34-35). In this process, you will also need to reword your focal problem as an outcome – this is an important card to watch out for, since it is the one problem that the group felt very strongly about.

STEP 2

Review the positive cards. You might need to reword some of them to make them a little more realistic. Sometimes this requires revisiting the problem analysis chart, rewriting the problem statement, and checking on some of your original ideas. If the group works collectively on this task, it often allows for a deeper understanding of the problem and what needs to change in order for that problem to be reduced.

STEP 3

Draw connecting lines between all of the positive cards. The solutions chart should look very much like the problem analysis chart but showing positive outcomes. You can then add or delete cards to ensure that there is a clear and logical flow in content between the solution cards stated at the bottom of the chart and those at the top. By reading one card at a time -

from the bottom to the top – you should start seeing a series of solutions which the group is proposing can be used to tackle the original problem.

STEP 4

You might start to see clusters – or groups of solution cards that talk about the same or similar things. Draw a line around those cards. Each cluster actually represents an area around which HIV/AIDS activities can be planned – commonly referred to as a strategic area of HIV/AIDS intervention.



You need to summarise the session using the following notes.



The solutions chart represents a broad range of strategies that can be adopted in order to reduce the impact of HIV/AIDS on both individuals and communities. In the solutions chart we can see that however big or small the intervention, it has the potential to make a measurable contribution in the broader fight against the pandemic.

Each card represents a positive course of action that could impact, directly or indirectly, on the broader focal problem that we identified as being at the centre or the 'heart' of our theme.

The Solutions Chart

An example

When the group was asked to transfer the chart from one that was filled with problems into one that showed solutions, they came up with the following ideas:

That as a church we need...

- To walk with each other...
- To empower...
- To reach out to communities...

We need to ensure that there is an **openness within the church** to discuss HIV/AIDS. This includes:

- ✓ involving people living with HIV/AIDS in all of our planning and discussions and that this involvement should not just be for the sake of 'including' people;
- ✓ ensuring that the language we use to speak about AIDS is appropriate and sensitive (eg. that we don't talk about victims or sufferers but people living with HIV/AIDS);
- ✓ talking about HIV/AIDS in the church like any other life-threatening or terminal disease,
- ✓ talking about HIV from a human rights perspective and that people right's particularly those living with HIV should be respected;

In order to break the current stigma associated with HIV/AIDS, we need to **train clergy** to become familiar with - and be knowledgeable as 'teachers or facilitators' - about all aspects of HIV/AIDS.

We also need to ensure that each church has an 'external' education programme, which deals with how we 'bring up' our children to be familiar with HIV and to accept those living with HIV.

We need to **share amongst ourselves** within our communities the little we have. This includes:

- ✓ working together to solve problems in a community spirit;
- ✓ sharing resources with one another when someone is in need; and
- ✓ working in a more organised way to manage both the above.

We need to **form support/counselling groups** for those that are HIV+ and also for those families that have been affected. This requires that each church establish a strong link to community-based VCT centers; include the issue of HIV/AIDS in all marriage counselling sessions; and to pastoral counselling in general.

We need to **establish strong links to hospices** in the community so that members of the church are able to both support these structures and access support from them in the terminal stages of illness.

We need to **initiate home based care programmes** which ought to include:

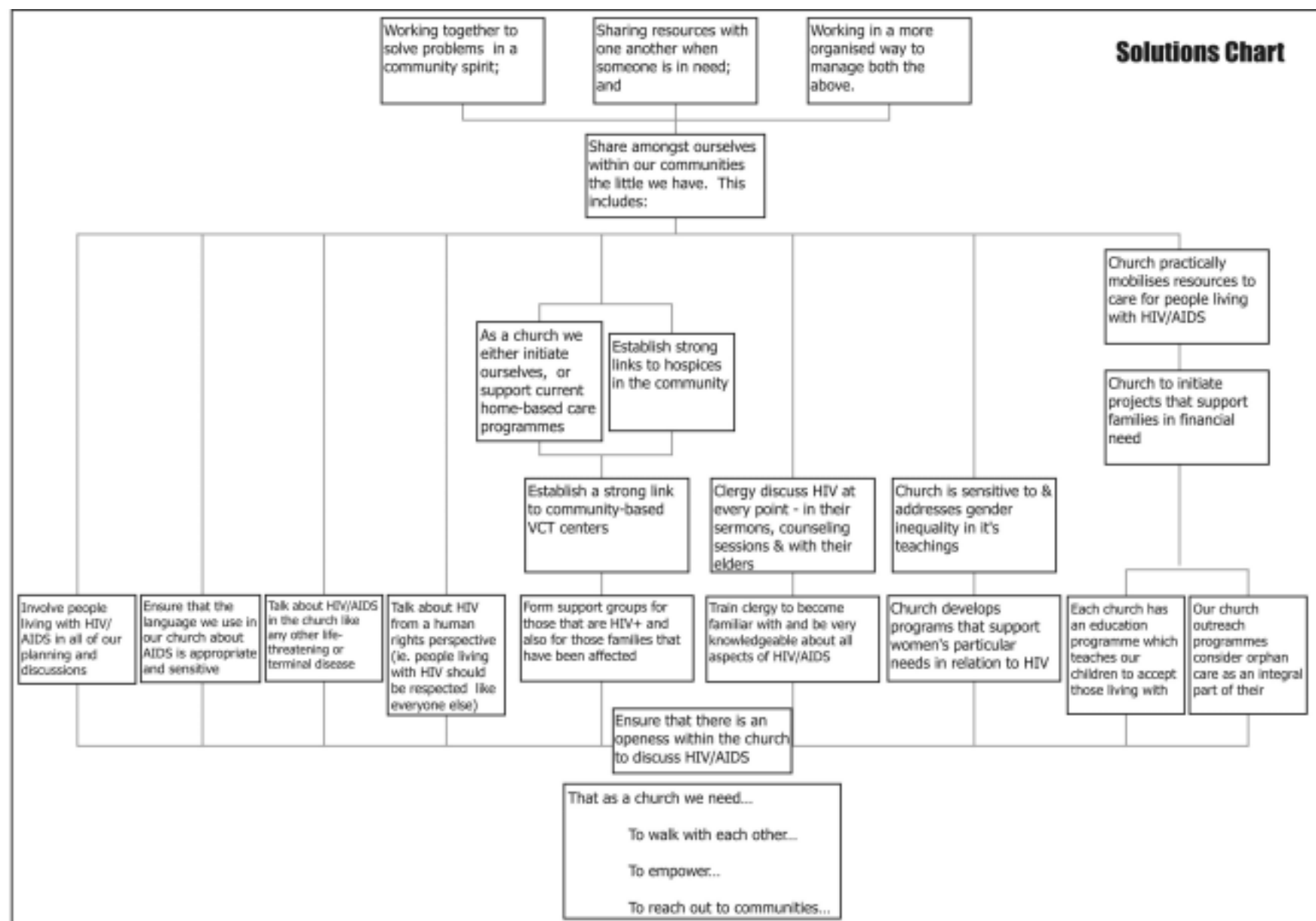
- ✓ home visits which offer both hope and prayer and advice - and practical care & support;
- ✓ care which is linked to accessing medicine;
- ✓ care which is monitored.

Caring programmes need to take into consideration the particular need for **orphan care**. The church ought to consider keeping a register of information about orphans and their parents, and keep track of those orphans that are 'out of school'. The church also needs think about and plan for - how it will offer support to child-headed households.

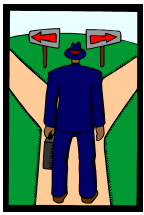
Initiate projects that **support families in financial need**, for example develop income generation projects & raise money within the parish for school fees for orphans.

The church needs realistically and **practically mobilise resources** to care for people living with HIV/AIDS. In other words, every year it needs to set aside a portion of its budget for HIV/AIDS. Resources also need to be set aside for the management of the church's HIV programme (ie. in terms of personnel).

We need to develop programs that recognize the particular needs of **women** in relation to HIV - and discuss the importance of gender equality in all relationships.



Making strategic choices 



STEP THREE: MAKING STRATEGIC CHOICES



OUTCOMES

- To make strategic choices about which objectives the church can reasonably work towards achieving.
- To apply various criteria to the strategic options identified in Step 2 of the planning process and make appropriate choices based on these.



RESOURCES

Appendix 2, prompt sheet 2 (make a photocopy for each participant)



TIME

3 hours



METHODS

You introduce the session.



One project intervention cannot solve all the problems at once. In developing a plan we need to consider the different options that are available. We also need to consider what the most practical strategy would be to reduce or eliminate the problem. Making strategic choices about the direction of an HIV/AIDS programme or interventions is never easy. Each cluster of cards on the solutions chart in Step 2 represents a strategic area that could be chosen as an HIV/AIDS intervention. The question is:

How do we go about choosing the best option for us to commit ourselves to?

ACTIVITY 1



Use the prompt sheet. Introduce the idea of making strategic choices and what factors to consider when making these choices. The group may add additional factors that they think are important to consider when choosing a particular course of action.



Appendix 2: prompt sheet 2

ACTIVITY 2



Get the participants into their theme groups. Hand out a copy of the prompt sheet to each participant. Then follow these steps:

1. Theme groups study the solution clusters on the solutions chart. Each cluster of cards represents a potential strategy that the church can implement to reduce the current problems.
2. Eliminate those strategies which are:
 - Unrealistic
 - Not within your field of expertise or capability
 - Already being tackled by an existing programme, organisation or institution in your area.

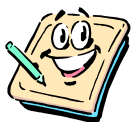
3. Theme groups must now select the strategies on the solutions chart that they think the church community could realistically address. Using the prompt sheet the groups should consider the following criteria when selecting strategies:

- Are there sufficient resources available to implement the strategy?
- What will be the extent and level at which these strategies will impact on the problem? Will this help solve the problems?
- Are there leaders or champions to drive and support particular strategies?
- Which strategies address the perceived priorities and needs of the community?
- Is the strategy appropriate for the group to address – or is there another organisation better positioned to take this on?
- How sustainable is the strategy?

Get the theme groups to report back their selected strategies to plenary.



You need to summarise the session using the following notes



You have now selected broad strategies, which are realistic and appropriate for your church community to build its HIV/AIDS interventions around. The next step is to formulate action plans for each of these selected strategies. This fourth step in the planning process involves developing objectives and activities, and forms the beginning of the church's draft action plan for HIV/AIDS interventions.

**Developing objectives &
activities**





STEP FOUR: DEVELOPING OBJECTIVES AND ACTIVITIES

Once strategic options have been chosen it is necessary to break these down into measurable and realistic steps that you can develop into a workable HIV/AIDS programme. In this section we will set the objectives and activities which will guide the church's future HIV/AIDS programmes.



OUTCOME

- To transform broad objectives into measurable activity plans - including allocating responsibility and time frames.



RESOURCES

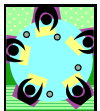
Appendix 1, worksheet 6 (make a photocopy for each participant)

Appendix 2, prompt sheet 3 (make a photocopy for each participant)



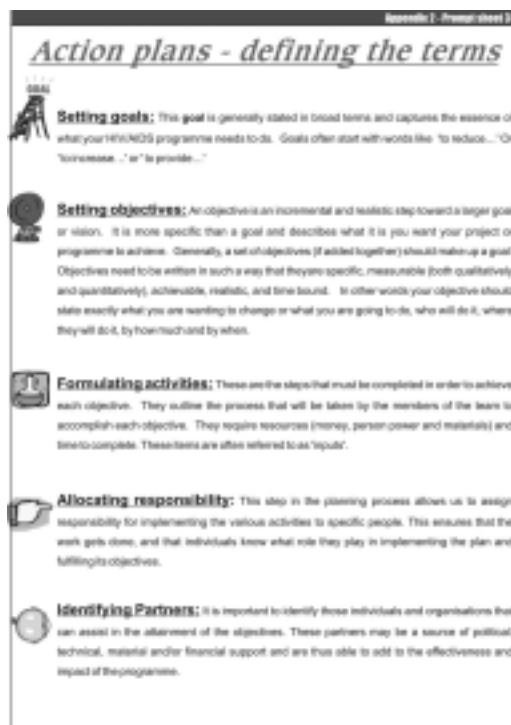
TIME

2 hours



METHODS

Each participant gets a copy of the prompt sheet. Using the prompt sheet, explain the definitions of the terms that will be used in this section i.e. goals, objectives, activities etc.



Appendix 2: prompt sheet 3

ACTIVITY 1



Participants remain in their theme groups.

Encourage the theme groups to each create a statement that sums up what the group hopes to achieve or to change in the next few years in relation to their theme. Write this GOAL statement on flipchart paper, using the grid on the worksheet as a guide.



Developing Objectives and Activities:				
Goal _____				
Objective 1				
Activities	Resources	Time Frame	Responsibility	Partners
Objective 2				

Appendix 1: worksheet 6

ACTIVITY 2

Refer back to the strategic options selected in Step 4. We need to now refine the strategies that were chosen and transform them into attainable **objectives**. The theme group now rewords these strategies into clear objectives using prompt sheet 3 as a guideline.
(see example of an action plan on the next page)

One person in each theme group should write up the group's action plan on flipchart.



Action Plans

An example

GOAL : To build a caring church that provides holistic and non judgemental care and support to those infected and affected by HIV/AIDS within one year

OBJECTIVE 1: To ensure there is openness and willingness within the church to discuss HIV/AIDS

<u>ACTIVITIES</u>	<u>RESOURCES</u>	<u>TIME FRAME</u>	<u>RESPONSIBILITY</u>	<u>PARTNERS</u>
Involve people living with HIV/AIDS in all planning and discussions	HIV positive people Community health workers	Immediately	All church leaders	Local associations of people living with HIV/AIDS;
Training clergy to become familiar with all aspects of HIV/AIDS	Training materials Trainers	Phase in over 3 months	Provincial and diocesan	AIDS service organisations in the community

OBJECTIVE 2: To form support/counselling groups for HIV positive people and their families

<u>ACTIVITIES</u>	<u>RESOURCES</u>	<u>TIME FRAME</u>	<u>RESPONSIBILITY</u>	<u>PARTNERS</u>
To establish strong links with community-based VCT centres	VCT centres Volunteer counsellors	Phase in over 6 months	Diocesan	Community-based VCT centres; community health workers; private health care facilities; traditional healers
To include the issue of HIV/AIDS in all marriage counselling sessions and pastoral counselling in general	Guidelines for pastors HIV/AIDS promotional material Trained counsellors	Over 3 months	Diocesan and parish	Community counselling services

ACTIVITY 3

Groups now break each objective into a series of activities using prompt sheet 3 and the example on the opposite page. They have to specify the time frame for completion. They also need to decide who will be responsible for ensuring that activities take place.



ACTIVITY 4

Each member of the theme group assumes a character role:



character 1
archbishop



character 2
bishop



character 3
priest/deacon



character 4
laity

Note:

It is best if individuals choose a character that is different to the one they assume in real life. For example, the bishop may want to play the role of the priest, whilst a priest in the group may want to take on the role of laity.



Participants need to reflect on the draft action plans they have drawn up in their theme groups and decide what role their characters will play in making these plans a reality.

Each character must write down the activities that they are able to get actively involved in. These are shared in the bigger group and discussed. For an example of how different positions in the church can all play a role in achieving set objectives, see page 45.



You need to summarise the session using the notes below.



Participants now have the skeleton of a **draft action plan** for how their local church community is going to respond to the issues identified as being priority in relation to HIV/AIDS. This step has also allowed them to explore the **roles and**

responsibilities of the different levels and people in the church structure in implementing these plans.

We can see that **all levels in the church have** a role to play in HIV/AIDS activities, from Archbishop to laity. **To turn strategic plans into action requires intervention at all these levels.**

Responsibilities for HIV/AIDS interventions

An example

That the Archbishop:

- ought to network with other organizations and institutions on a national level to advocate for increased collaboration between the church, health clinics, hospices and other service providers as they collectively care for people living with HIV;
- should use his position to advocate for better and more accessible treatment from the Government for those living with HIV+; and
- as a leader, initiate a process whereby he and all the Bishops, followed by the Priests at a local level, participate in a comprehensive HIV/AIDS training programme.

That the Bishop:

- ought to initiate a replication of the above training in his own diocese;
- allocate a specific budget for HIV/AIDS within the diocese;
- support the local parish priests as they incorporate HIV into the liturgies & sermons.

That the Priest/Deacon:

- participate in HIV/AIDS training at a local level and set up a local AIDS committee (with its own budget);
- initiate HIV/AIDS educational programmes within the parish;
- take a leadership role in talking openly about HIV/AIDS;
- meet with local health clinics and hospices to form links between the church's AIDS committee and the outreach work that other organizations working in the local community are providing;
- initiate outreach programmes that support people living with HIV; take care of orphans and vulnerable families.

That the Laity:

- serve as counsellors and home-based carers in the local community;
- are trainers and facilitators within the local educational programmes;
- are foster parents of children that have been orphaned to HIV/AIDS. It was noted that the latter role ought also to be assumed by the Priest, the Bishop and the Archbishop.

Monitoring and evaluation





STEP FIVE: MONITORING AND EVALUATION



OUTCOMES

- To consider the factors that need to be taken into account when monitoring the progress and measuring the success of an HIV/AIDS plan.
- To explore how one can track the process of putting this plan into action.



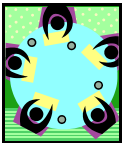
RESOURCES

Appendix 2, prompt sheet 4



TIME

2 hours



METHOD

Introduce the concepts of monitoring and evaluation. Use the prompt sheet and the text box below to guide your introduction.



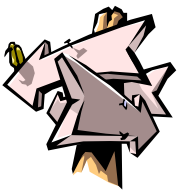
Appendix 2: prompt sheet 4



Monitoring and evaluation are essential components of the planning process. An evaluative process provides opportunities to consider how well our HIV/AIDS interventions are working and to what extent they are meeting the needs of the community.

In order to assess their HIV/AIDS programmes, programme implementers will often establish - from the outset - what kind of information they will collect about their activities. Implementers might decide to assess the quality of their work, or how efficient and effective they were in delivering what they said they would in their original work plan, or what impact their interventions have had on the lives of community members.

Implementers will often look for reliable signs or markers that tell them that their work is progressing or that the outcomes that they desired have occurred. These signs are referred to as **indicators** – and are accompanied by appropriate evidence or data.



For example, a project that aims to increase a local youth group's knowledge of HIV/AIDS might record how many youth it consistently worked with over a period of time. The youth would complete a pre- and post- training questionnaire. This will help them to assess changes in their knowledge and attitudes as a result of the training.

Both the participant records and the questionnaires are sources of information that will provide the programme implementers with an indication about whether the programme was sufficiently appealing to youth (and thus supported their continued involvement in the programme) and whether youth were able to learn new information and report on acquiring new skills.

The acceptability of the programme to youth and the extent to which youth were able to acquire new skills would be important indicators of how successful the programme had been for that community.

ACTIVITY 1

Each theme groups presents their plans (from Step 4) to the bigger group.

After each presentation you need to ask the following questions:



1. Reflect on your draft plans. What outcomes or results do you want to see a year later to show that the strategies you have adopted have been effective and that your work has had an impact?



2. What would indicate to you that the activities you have implemented have been effective in changing conditions in your church community and/or the broader community?

Get the participants to discuss the questions in plenary and write the responses up on flipchart.



For an example of how to apply questions 1 and 2 above to a real-life situation, see page 49.



You need to summarise the session



In this step the group has begun to consider the key elements that need to be incorporated into a monitoring and evaluation plan for their HIV/AIDS interventions.

Stress that whilst monitoring and evaluation is Step 5 of the planning cycle, it forms an integral part of all the previous planning steps, and allows us to measure the progress of our HIV/AIDS interventions in a systematic and continuous manner.

Monitoring and Evaluation

An example

These are some of the activities that the Priest/Deacon planned to implement:

To participate in HIV/AIDS training at a local level and set up a local AIDS committee (with it's own budget).

To initiate HIV/AIDS educational programmes within the parish.

To take a leadership role in talking openly about HIV/AIDS.

To initiate outreach programmes that support people living with HIV and take care of orphans and vulnerable families.

These are some results the planning team would like to see a year later:

Priest/Deacon is now trained in HIV/AIDS and is talking knowledgeably and sympathetically about HIV in their sermons.

Priest/Deacon has initiated HIV/AIDS educational programmes for youth that form part of the day-to-day parish activities.

Priest/Deacon has established a local AIDS committee, set aside money for it's activities and has designated a member of the parish to coordinate the activities of the committee.

Priest/Deacon has established a partnership with a local AIDS service organisations that takes care of AIDS orphans. This partnership has the following outcomes:

- Identifying foster parents from within the congregation.
- Use of the parish hall as a day care centre.
- Providing food and basic necessities to child-headed households in the community.

These are some of the things that would indicate that the activities implemented have been effective in changing conditions in the church community and broader community:

Increased awareness about HIV/AIDS and an openness to discuss matters related to HIV/AIDS within the congregation.

Church youth have increased knowledge about HIV transmission and prevention, and are more accepting of those infected and affected by HIV/AIDS.

A core group of the congregation are actively involved in co-ordinating and promoting local HIV/AIDS involvement by the church. The church's commitment to the HIV/AIDS needs of the community is clearly visible by the budget that they have set aside for local HIV/AIDS interventions.

Some church members have assumed responsibilities for fostering and caring for orphans from the local community. Church facilities are being used as a day care centre for HIV positive children.



WRAP UP

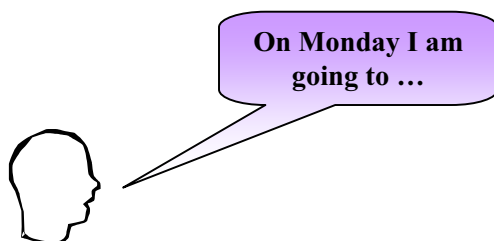
You have reached the close of the planning process, and you now need to briefly summarise what the group has achieved. Use the notes below as a guideline.



Through the planning process the group has:

- Analysed the specific situation in which HIV/AIDS presents itself in their communities
- Explored the various issues and implications that HIV/AIDS raises, focusing on the 6 themes:
 - 🚫 **Care**
 - 🚫 **Counselling**
 - 🚫 **Death and dying**
 - 🚫 **Leadership**
 - 🚫 **Pastoral care**
 - 🚫 **Prevention**
- Considered **possible solutions** to some of these problems and **identified actions** that could be taken to reach selected objectives.
- Explored the **role that each level** in the church can play in HIV/AIDS interventions.
- Began to **identify markers** along the way that will need to be **tracked** to **monitor the progress** of their HIV/AIDS interventions and determine its success.

CLOSING SESSION



METHOD



You are now ready to close the planning session and for the group to say their farewells. The two exercises below are examples of how you may want to facilitate the closing session.

ACTIVITY 1:

Ask participants to do a very quick go-around. They have to briefly state what their first actions after this planning meeting are going to be, in relation to HIV/AIDS. Limit participants to a few words – their actions need to be practical and realistic and can be single small activities. Get a volunteer to make notes.

Get each participant to write down their action commitments on a small piece of paper and place it in their bible. They should read it back in 12 weeks time. It may be useful for you to send out gentle reminders to the participants after a week. This could be in the form of a summary of who committed to do what, as well as a summary of the main proceedings and decisions of the workshop. Sometimes participants have the best intentions after a well-run and stimulating workshop, but get caught up in their daily challenges and routines, which prevent them from taking action. Periodic polite reminders support the participants in turning words and policies into actions.

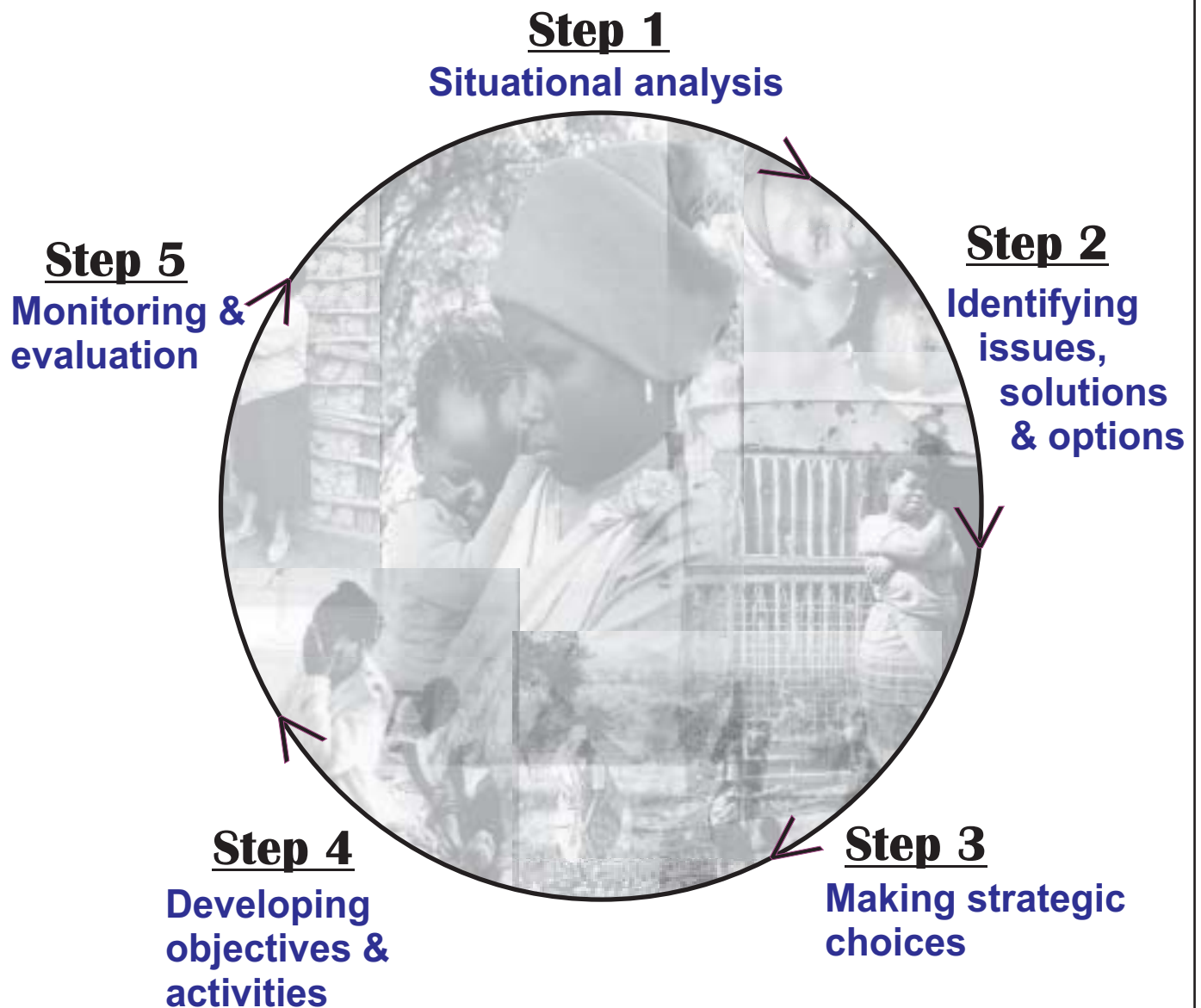
ACTIVITY 2:

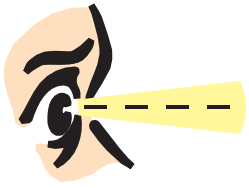
Ask the participants to stand in a circle. They need to have a look around at all the participants in the circle. Tell them that this is the group that has worked hard in the planning session. This is the group that achieved the outcomes if this planning meeting. This is the group that is going to make an impact in the struggle against HIV/AIDS. Allow them to stand quietly for a few minutes. Thank the group for their work and praise them for their efforts.

appendix

1

The planning cycle





What have we seen?

What have we heard?



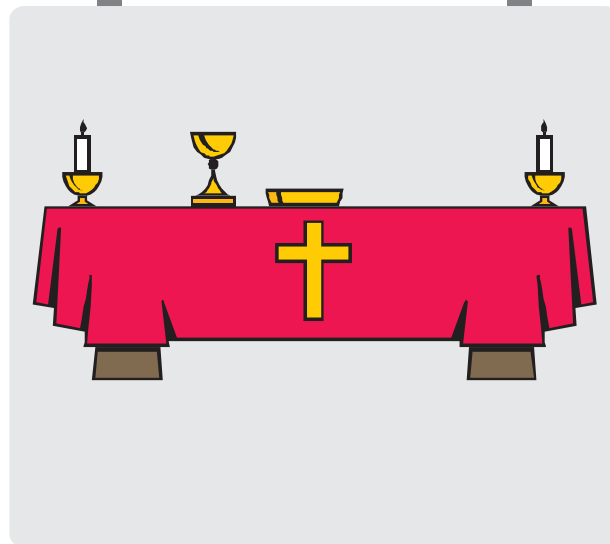
What have we felt?

What has been your personal
involvement in HIV/AIDS



Training

Care & support



Community outreach

Prevention

best practice best practice best practice best practice best practice best practice best practice

[illegible]

ctice best practice

- [illegible]

In May 2001, The Church Province of Southern Africa identified six areas of critical concern and three populations: women, orphans and people living with HIV/AIDS to guide the response of the Anglican community in relation to the HIV/AIDS pandemic. These areas were developed and determined by HIV/AIDS activists, public health specialists, and community development experts over a period of eight weeks.

These areas of concern can be both assessed and comprehensively planned for in the context of HIV with cross cutting concerns for women, orphans and people living with HIV/AIDS.

The 6 focal areas represent key elements without which critical decisions cannot be made about the impact of, and appropriate response to, the HIV pandemic in sub-Saharan Africa. Therefore all future planning by the Anglican Communion should consider these focal areas as a framework for HIV/AIDS interventions. The diagram below illustrates the 6 focal areas as well as some of the HIV/AIDS concerns represented by each.



Developing Objectives and Activities:

Goal _____

Objective 1

Activities

Resources

Time Frame

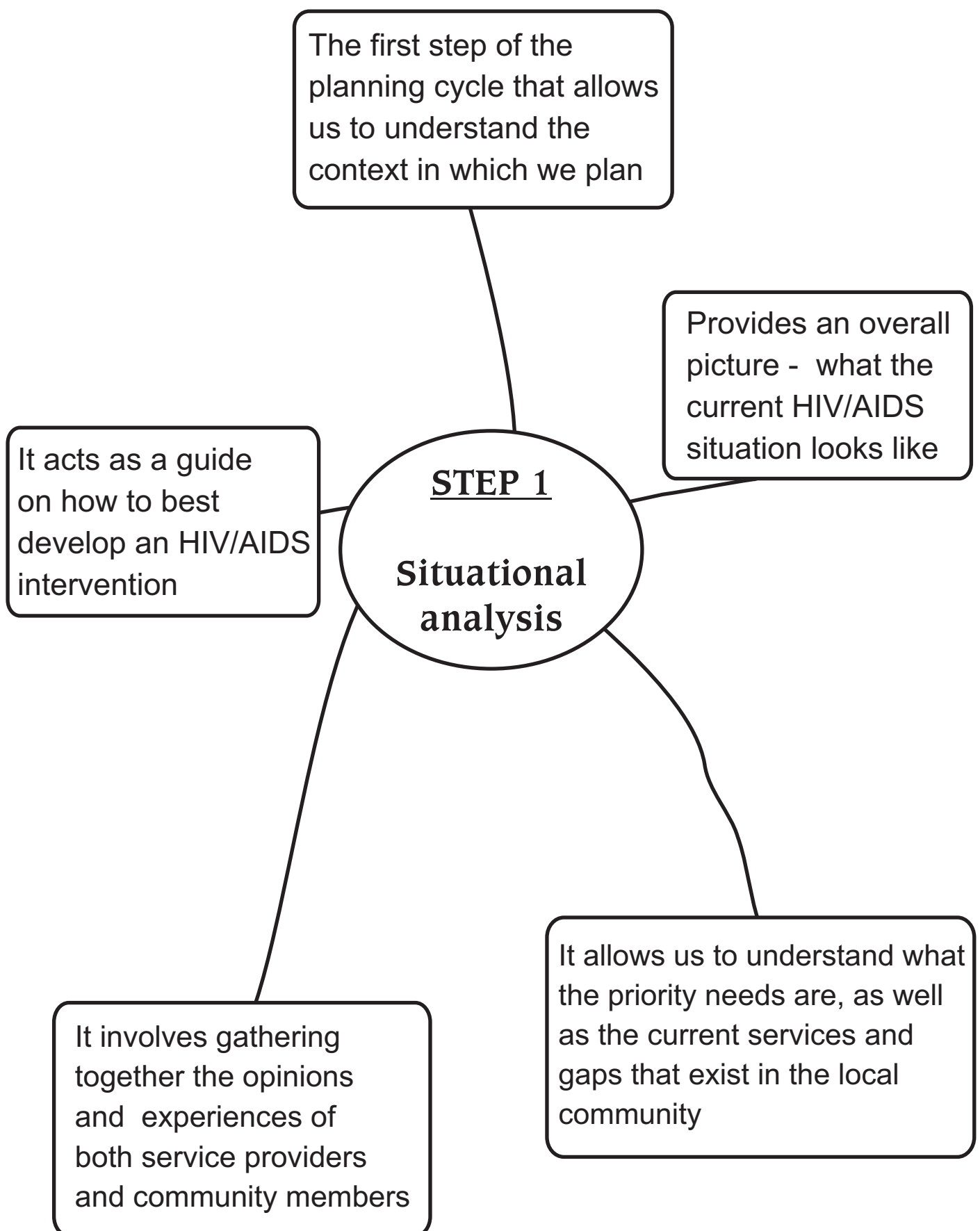
Responsibility

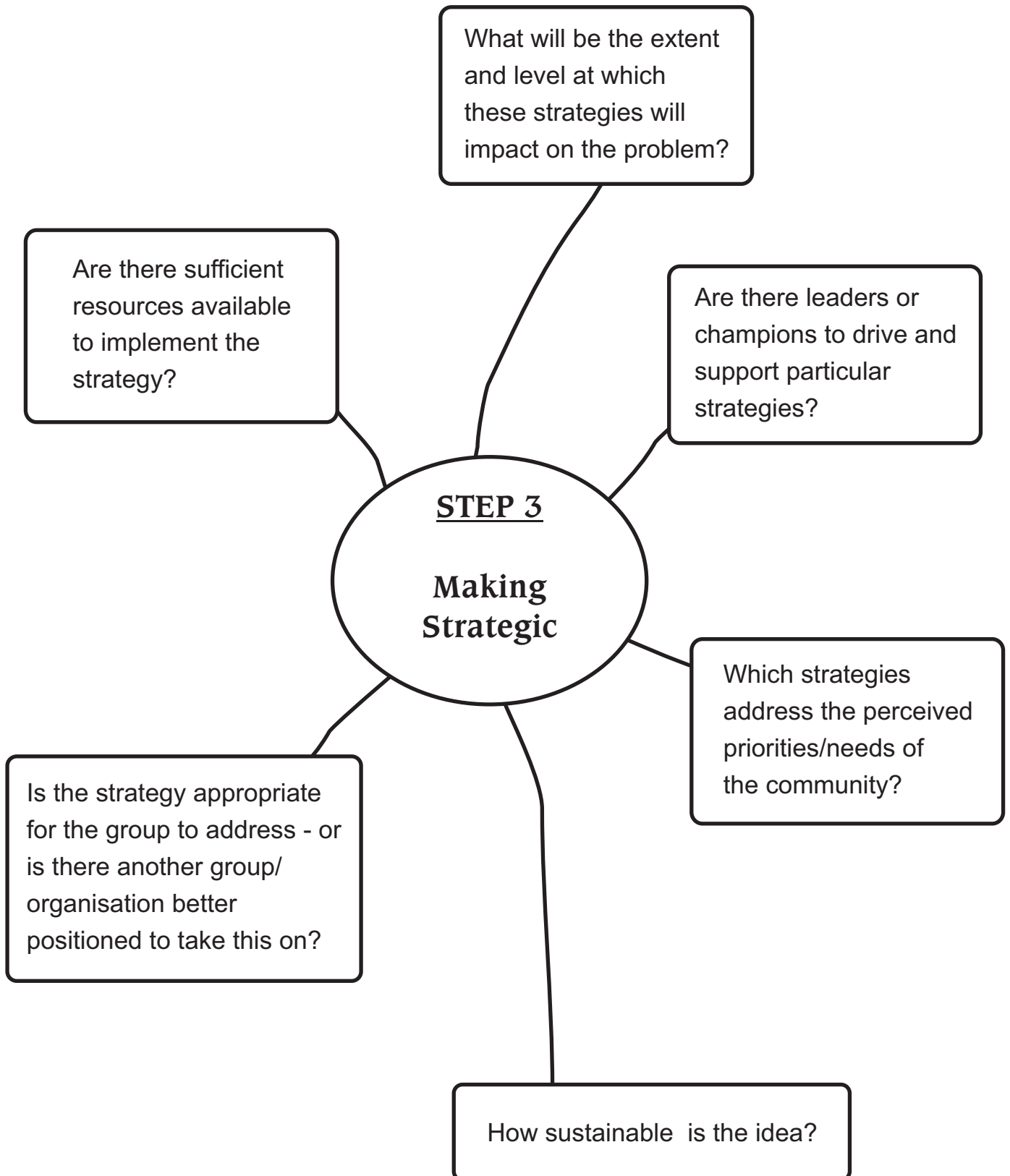
Partners

Objective 2

appendix

2





Action plans - defining the terms



Setting goals: This **goal** is generally stated in broad terms and captures the essence of what your HIV/AIDS programme needs to do. Goals often start with words like 'to reduce...' Or 'to increase...' or 'to provide...'



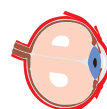
Setting objectives: An objective is an incremental and realistic step toward a larger goal or vision. It is more specific than a goal and describes what it is you want your project or programme to achieve. Generally, a set of objectives (if added together) should make up a goal. Objectives need to be written in such a way that they are specific, measurable (both qualitatively and quantitatively), achievable, realistic, and time bound. In other words your objective should state exactly what you are wanting to change or what you are going to do, who will do it, where they will do it, by how much and by when.



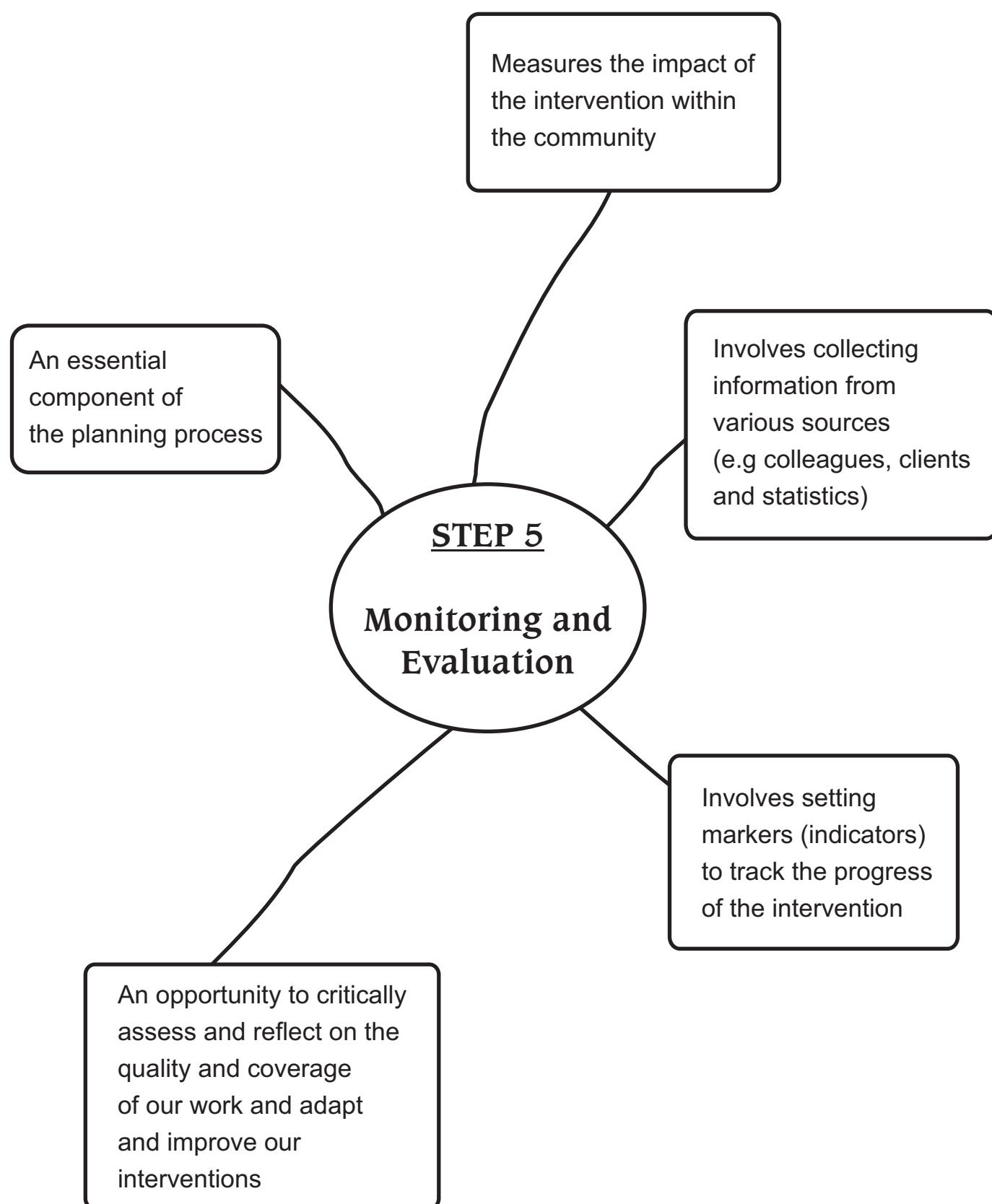
Formulating activities: These are the steps that must be completed in order to achieve each objective. They outline the process that will be taken by the members of the team to accomplish each objective. They require resources (money, person power and materials) and time to complete. These items are often referred to as 'inputs'.



Allocating responsibility: This step in the planning process allows us to assign responsibility for implementing the various activities to specific people. This ensures that the work gets done, and that individuals know what role they play in implementing the plan and fulfilling its objectives.



Identifying Partners: It is important to identify those individuals and organisations that can assist in the attainment of the objectives. These partners may be a source of political, technical, material and/or financial support and are thus able to add to the effectiveness and impact of the programme.



appendix

3

Facilitation Tip

TIPS FOR DIVIDING PARTICIPANTS INTO SMALL GROUPS

It is useful to have a variety of ways of getting participants into groups. Sometimes groups work well together. However, this is not always the case. Some groups are unproductive due to conflict or incompatibility.

It may be useful to rotate groups so that participants get an opportunity to work with a range of people. Look out for participants who do not allow the rest of their small group members much space to participate - their group members may feel frustrated and withdraw from the process.

Options:

Pass a box round the room with small cards face down in the box. Make small cards of hands in different positions. Participants have to move their hands according to the hands on their cards in order to find their groups.

or

You can also pass a basket of sweets round. Have five of each kind of sweet. Participants have to work with people who have the same kinds of sweets as them.

or

A way to get participants into groups is to make small balls made from newspapers. Crumple sheet of newspaper up about the size of a small hand- and cover with masking tape. Make one ball for each person. Use a koki pen to write numbers on the balls. If you have a group of 30 people, you will number the balls from 1 to 6. You will thus have five number 1's and so on. Tell the group to throw the balls in to the air and instruct them to keep throwing the balls to each other. Let this continue until everybody has a ball. Then the participants with the same number balls have to get into groups. This is a fun way which helps to relax participants.

or

Offer six different fruits to participants. Ask each participant to choose one kind of fruit. If you have a group of 30, you will have six of each of the following, for example: bananas, apples, oranges, lemons, grapes, naartjies. Once each person has a piece of fruit, tell them to get into groups of mixed fruit. This means that no group will have two of the same kind of fruit. Alternatively all participants who chose the same fruit can get into a group.

💡 Facilitation Tip 💡

TIPS FOR GETTING PARTICIPANT TO SHARE THEIR EXPECTATIONS

It is essential that a brief space be given to participants to share their expectations. It is useful to keep referring to and building on these expectations.

POT OF PROMISES

Either use a traditional pot, or a large cardboard box that has the words "pot of promises" written on it. You also need a large wooden spoon. Ask each participant to say what their expectations for the workshop are. As they speak, they stir their expectations into the pot, and pass the spoon on to the next person who does the same. At the end when everybody has had a chance, give the pot a stir and say:

We have stirred all out expectations into this pot. We hope this workshop will allow for most of these expectations to be fulfilled. We would like to see these expectations exceeded! However, there is only one way this could happen. We can only get what we want from this pot if we all work hard, co-operate and take responsibility for our own participation.

The pot can be left in the venue as a reminder. When participants go off track, remind them of the aims of the workshop and their expectations.

HOPES

You can have your own hope list as a facilitator and ask the participants to contribute to this list. This is useful as they get a sense of what the workshop wishes to achieve and also the opportunity to air their expectations. It is particularly useful if you are dealing with a high conflict group, as you can include hopes such as "I hope you listen to each other..." or "I hope you can put your differences aside for the duration of this workshop"

DRUM FOR AFRICA

Pass an African drum around. Each participant gets to share her/his expectations while drumming. At the end, you could point out that if we all work together with a common goal, the sound we make will be heard far beyond the confines of this room.

Facilitation Tip

HOW MUCH AT RISK ARE YOU TO HIV INFECTION?

This checklist is designed to allow individuals to reflect on their own attitudes, beliefs, behaviour and life events in relation to HIV/AIDS. The total risk score calculated after completing the checklist will give you some indication of your individual risk to HIV infection.

How long has AIDS been in your community?







Number of years.....

Read the questions below and score your responses in the box.

Score: Yes = 10 points

No = 0 points










Since this time (ie. the number of years AIDS has been in your community).....

- | | | |
|---|---|--------------------------|
|  | Have you had unprotected sex with someone else other than your current partner? | <input type="checkbox"/> |
|  | Have you been exposed to possibly non-sterile invasive procedures (eg. Tattooing; piercing; circumcision; scarification etc.)? | <input type="checkbox"/> |
|  | Have you received a blood transfusion? | <input type="checkbox"/> |
|  | Have you used alcohol to the extent that you could not remember your behaviour? | <input type="checkbox"/> |
|  | Have you used alcohol to the extent that you could not remember who you had sexual encounters with and whether you used protection? | <input type="checkbox"/> |
|  | Have you against your will been forced to have sex? | <input type="checkbox"/> |

SUB TOTAL

Score: Yes = 0 points

No = 10 points

- | | | |
|---|--|--------------------------|
|  | If you have been forced to have sex, did you receive medical treatment afterwards? | <input type="checkbox"/> |
|  | Have you told your current partner everything about your life? | <input type="checkbox"/> |
|  | Has your current partner told you everything about his/her life? | <input type="checkbox"/> |
|  | Have you tested for HIV during the past 1 year? | <input type="checkbox"/> |
|  | Has your current sexual partner been tested for HIV in the past 1 year? | <input type="checkbox"/> |
|  | Have you and your sexual partner talked about going for an HIV/AIDS test? | <input type="checkbox"/> |
|  | Have you ever used a condom in a sexual encounter? | <input type="checkbox"/> |
|  | Do you use condoms consistently and correctly? | <input type="checkbox"/> |
|  | Have you always worn gloves/protection when dealing with injured/bleeding people? | <input type="checkbox"/> |

SUB TOTAL

TOTAL RISK SCORE

 /150

In doing this HIV/AIDS 'risk checklist' you will have reflected on some of the behaviours that might have placed you at risk of HIV infection. On this basis you may wish to consider if going for an HIV test could be beneficial to you and/or your partner. If you decide to test it would be important to find out from your local priest where the

appendix

4

Resource List

Websites:

AIDS Education Global information System (AEGIS)	www.aegis.org
International Association of Physicians in AIDS Care	www.iapac.org
Red Ribbon	www.redribbon.co.za
AIDS Consortium	www.aidsconsortiom.org.za
I-clinic's AIDS page	www.iclinic.co.za/topics/aids/aods.htm
Joint United Nations Programme on HIV/AIDS	www.unaids.org
Panos Institute	www.panos.org.uk
Medecins Sans Frontieres	www.msf.org
Treatment Action Group	www.aidsinfoyc.org/tag
African Counselling Network	www.geocities.com/kim1122a/
Southern African AIDS Information Dissemination Services	www.saf aids.org
World AIDS Statistics	http://167.160.195.60/html/aidsstatworld.html
The World Health Organisation	www.who.int
The World Council of Churches	www.wcc-coe.org

Other resources:

1. Anglican Consultative Council, *The Truth Shall Make You Free The Lambeth Conference 1998*.
2. Atkinson, Ecls D.J D.H Field, *New Dictionary of Christian Ethics and Pastoral Theology*. IP 1995.
3. Byamugisha, Rev. Gideon B. *Am I My Brother's Keeper? Reflections on Genesis 4:9. Vol. 2. 1998; Aids, the Condom and the Church Vol. 1. 1998; Breaking the Silence on HIV/AIDS in Africa, How can Religious Institutions Talk About Sexual Matters in Their Communities? July 2000*.
4. Catholic AIDS Action, *Caring for Ourselves in Order to Care for Others, Handbook for Death and Dying*, Windhoek, Namibia.
5. Cornwall, Andrea, *Initial Feedback from Stepping Stone Users*, November 1997.

6. Futter, Mel, *Home Based Family-Care in Namibia A Practice Manuel for Volunteers*, Catholic AIDS Action, 1994.
7. Hauerwas, Stanley *Suffering Presence: Theological Reflections on Medicine, the mentally handicapped, and the Church*.
8. Kaleeba, Noerine. Namulondo Kadowe, Joyce. Kalinaki, Daniel. Williams, Glen. *Open Secret: People facing up to HIV and AIDS in Uganda, Strategies for Hope*, ACTION AIDS London, July 2000.
9. MAP International, *Facts and Feelings About AIDS; AIDS in Your Community and Helpers for a Healing Community: A Pastoral Counselling Manual for AIDS*, The Christian Health Association of Kenya and the Institute for Development Training, 1996.
10. Meyer-Simon, Janine, *Children in Distress (CINDI), " HIV/AIDS Best Practice Series*, Department of Health, South Africa 2000 .
11. Oden, Thomas C. *Pastoral Theology: Essentials of Ministry* OUP 1983.
12. Public Media Centre and the AIDS National Interfaith Network, *Faith & AIDS*, American Faith Communities Respond to the AIDS Epidemic, 1997.
13. South African National Council for Child and Family Welfare "*HIV/AIDS and the Care of Children*, July 1999.
14. Whiteside, Alan and Sunter, Clem, *AIDS: The Challenge for South Africa, Human & Rousseau Tafelberg, 2000*.
15. Whiteside, Alan *AIDS BRIEF for Professionals: Religious Leaders*, Health, Economics and HIV/AIDS Research Division (HEARD), University of Natal, South Africa.
16. World Council of Churches Study Document, *Facing AIDS: The Challenge, the Churches' Response*, 2001 WCC Publications.

appendix

5

Commonly asked questions

A person who is infected with HIV can look and feel healthy for up to ten years or more before signs of AIDS appear. But HIV steadily weakens the body's defense (immune) system until it can no longer fight off infections such as pneumonia, diarrhea, tumors and other illnesses. All of which can be part of AIDS. Unable to fight back, most people die within three years of the first signs of AIDS appearing.

1. How can one contract HIV?

AIDS is mainly a sexually transmitted disease. Most of all HIV infections have been transmitted through unprotected sexual intercourse with someone who is already infected with HIV. HIV can also be transmitted by infected blood or blood products (as in blood transfusions), by the sharing of contaminated needles, and from an infected woman to her baby before birth, during delivery, or through breast-feeding. HIV is not transmitted through normal, day-to-day contact.

2. Can I get AIDS from "casual contact" with an infected person?

No. This means that it is OK to play sports and work together, shake hands, hug friends or kiss them on the cheek or hands, sleep in the same room, breathe the same air, share drinking and eating utensils and towels, use the same showers or toilets, use the same washing water and swim in the same swimming pool. You cannot get infected through spitting, sneezing, coughing or through tears or sweat, or through bites from mosquitoes or other insects.

3. How can I recognize if someone is infected with HIV?

There is no way of knowing whether someone is infected just by looking at them. A man or woman you meet at work, school, or a sports stadium; in a bar or on the street might be carrying HIV - but look completely healthy. But during this time of apparent health, he or she can infect someone else.

4. What should I do to protect myself from HIV?

There is no vaccine to protect people against getting infected with HIV. There is no cure for AIDS either. This means that the only certain way to avoid AIDS is to prevent getting infected with HIV in the first place.

5. What is safer sex?

You are safest of all if you do not have sexual intercourse. You are also safe if you are in a stable relationship where both you and your partner are free of HIV and neither of you has other sex partners. Sex without penetration is another way to have safer sex that greatly decreases your risk of getting infected with HIV.

You can have a great deal of stimulation and pleasure through caressing, hugging, kissing, and massaging different parts of the body. Safer sex also includes using a condom - but, using a condom correctly, and using one every time you have sex. Learn how to negotiate the use of condoms with your partner.

6. What can I do to convince my partner to use a condom?

Some people think that sex is not as enjoyable if you use condoms - perhaps you feel this way because of a bad or embarrassing experience, but that is not a good reason to risk your life or the life of your partner by not using them!

Research has shown that when people use condoms the right way, and with confidence, there is little or no loss of stimulation or pleasure. For some people, it even lasts longer.

If you do not use condoms often, and if you still feel a bit awkward about using them, try practising a little by yourself. Just go out and get some condoms, read how to use them, practice using them, then use them every time you have sex.

7. Do you sometimes have sex without using a condom?

If you have had sex without a condom just one time, you have already put yourself in danger of infection with HIV. Maybe you have been lucky - maybe you have not yet been infected with HIV. You may not be so lucky next time. First of all, avoiding dangerous situations is the smarter way to go. Having casual sex is dangerous - but having casual sex without a condom is simply taking a needless and foolish chance of getting infected with HIV.

8. I have fallen in love, can I start cutting back on using condoms during sex?

Many people think that once they have fallen in love, it is all right to stop using condoms. Unfortunately, thousands of people around the world have become infected by their steady partner. Unless we are talking about a 100% mutually faithful relationship between two people who are both free of HIV infection, it is important to wear condoms every time you have sex. No matter how well you think you know the other person, you cannot tell if that person is infected with HIV.

9. How can I tell if I am in a safe relationship?

After a minimum of three months of a monogamous and mutually faithful relationship, a medical exam to show that both partners are free of any sexually transmitted disease is reassuring. If HIV-testing is available to you, a negative HIV test after a minimum of three months of your mutually faithful relationship would show that you are free of HIV. Of course, both you and your partner need to stay mutually faithful to ensure that you will stay free of HIV and STDs.

10. I think sex should always involve penetration to be enjoyable!

Non-penetrative sex, where the penis does not enter the vagina or anus, is a way to have safer sex that greatly decreases your risk of getting infected with HIV. Maybe you do not believe that non-penetrative sex can be as satisfying as penetrative sex. But you can give and receive a great deal of stimulation and pleasure through non-penetrative sex, such as mutual masturbation, massage, caressing, hugging, and kissing different parts of the body. It may take patience, practice, imagination and trying different things out with your partner, but when you become skilled at non-penetrative sex, you will find, as others have found, that it can be an exciting and sensual alternative.

11. What about oral sex, is it safe?

You need to know that the AIDS virus is present in sexual secretions, including the vaginal secretions of a woman and the semen (in both the pre-ejaculation lubricating mucus and the ejaculate, or "cum") of a man. This means that taking the partner's sexual secretions into the mouth can pose a risk of infection.

It is strongly advisable to carry out oral sex only with some kind of protection. You should use a condom on the erect penis, and place a thin rubber sheet or "dam" over the woman's genitals.

12. What about the risk of kissing - and what about "wet" or "tongue kissing"?

The AIDS virus is not found in the saliva of the mouth under normal conditions. So, when two healthy people kiss, or even kiss with touching tongues or inserting the tongue deeply into the other person's mouth, there should not be any significant risk.

However, everyone has times when there is bleeding from the gums or a small ulcer in the mouth. Some people have this almost all the time. If this is true for both individuals who are kissing, and if there is any exchange of blood between the two mouths, there is a potential risk that the virus could pass from one person to the next. Obviously, the risk would be higher in "wet" kissing. It is not possible to know exactly how important this risk is.

13. Can I have anal sex?

Maybe you have anal sex to avoid unwanted pregnancies. Or maybe you have anal sex because you believe that is how you can best avoid getting infected with HIV. Unfortunately, many people believe this myth. In fact, the opposite is true: the AIDS virus is more easily passed from an infected person to another person during anal sex than during vaginal sex.

In these circumstances, using a well-lubricated condom is absolutely essential for protection. Unlike the vagina, which produces secretions that lubricate vaginal sex, the anus does not produce lubricating secretions. Without such lubrication, the additional friction during anal sex can cause regular condoms to tear. In some places, it is possible to get condoms made especially for anal sex. If these are not available, you should really try to be on the safer side - look for other ways to have sexual satisfaction.

14. I am worried that I might have a sexually transmitted disease (STD).

You may have a sexually transmitted disease, such as gonorrhea or hepatitis B, if you have a burning sensation when you urinate. Signs of an STD in a woman may be unusual discharge or unexpected bleeding from the vagina during or after intercourse. A man infected with an STD may have a discharge from his penis, or he may have sores or discoloration on his penis.

If you think you have an STD, you should consult a doctor right away, get the full treatment you need, and ask for some advice on how to avoid this risk in the future.

If you have an STD, you have been given a very serious warning that you have been having unprotected sex, exposing yourself to risks by not using a condom with great care every time you have sex.

You may be lucky if you became infected with one of the curable STDs. But remember that AIDS is also a sexually transmitted disease, and that there is no cure or vaccine for it.

15. Have you noticed any sores or lesions on the genitals of your sex partner?

Never have sex if you know or suspect that either you or your partner has an STD. Any STD can increase the risk of catching or transmitting HIV. With an STD you have a 5 to 10 times higher risk of getting infected with HIV. For your own safety and that of your partner, DO NOT have sex if there is any chance that either one of you has an STD.

16. I have sex with a lot of different partners. Is that risky?

Yes, men and women who have many different sex partners run a higher risk of being exposed to and getting infected with HIV than do people who stay in a mutually faithful relationship with a single partner. The simple fact is that you increase your chances of being exposed to HIV every time you have sex with a different person. However, you can reduce your risk by always using condoms.

17. Are there people who are more likely to be infected with HIV than others?

Some people are, statistically, more likely to be infected with HIV than others.

- Both men and women who work as prostitutes are more likely to be infected with HIV because they have had so many sexual partners. Any one of these partners could have been infected with HIV and transmitted HIV during sex.
- People who inject drugs are also more likely to be HIV- positive, because the virus spreads so easily through injections using needles and syringes contaminated with HIV- infected blood.
- Men who have sex with men have a greater chance of becoming infected with HIV than do men who have sex only with women. This is because HIV is more likely to pass from an infected person to another person during anal sex than during vaginal sex. This is because anal sex can injure or tear the delicate lining of the anus and rectum, and bleeding from these injuries allows the virus to pass more easily into the body.

18. What about the risks of getting HIV through injecting drug use ("shooting drugs") - can that risk be reduced?

Obviously, to avoid the very high risk of being exposed to HIV in this way, it is best to use sterile, never-used needles and syringes, and to use them only once. If you have nothing available but already-used syringes and needles, the only way to be sure you are protected against HIV is not to inject drugs at all.

You may have heard that bleach has been recommended to disinfect drug injection equipment. But you should know that this is not guaranteed to be effective in killing HIV. If you decide to use this to reduce the risk of exposure to HIV, be sure that the product you use is full strength liquid household bleach.

First, wash out the syringe and needle with clean water to get rid of all traces of blood; then, completely fill and flush the syringe and needle with the bleach at least 3 times, leaving the bleach inside the syringe for at least a full 30 seconds, using fresh bleach each time. Finally, after the bleach, rinse the syringe and needle by filling several times with fresh, clean water to remove all traces of bleach.

19. What precaution should I take when I am at the disco or a bar?

Give some thought to what you do when you are at a disco. Some of the people you meet in discos are there every night and have gone out with many other people before you. Any one of the casual sex partners you meet there could be infected with HIV or another STD.

If you drink a lot of alcohol or take drugs, this will interfere with your judgment about many things, including sex. Think about it: being just "high", could kill you. When you lose control, you could get infected with HIV. Even if you think about condoms, you may not be careful enough to use them correctly.



20. What should I do if I think I might already have HIV?

If you think you might have HIV (if you have had unprotected sex, you may be starting to worry), and you would like to know for sure, ask your physician about getting an HIV blood test and some counselling. If you need to check it out yourself, many cities have testing centers where you can get an HIV test and some good counselling without even having to give your name.

21. What is the use of knowing whether or not I am infected?

It may take a great deal of courage to go and get the answer to this question. But it will permit you to get full and proper medical care should you be infected. By taking extra care, people with HIV infection can live for many years. If you are infected, you can find out what to do to stay as healthy as possible for as long as possible. For example, it is very important not to get another STD, or expose yourself to other types of infection.

There are two other reasons why it is important to know if you are infected.

-  First, if you are infected with HIV and have sex with other people, there is a great risk you could transmit the virus to them. In this situation, you need to prevent passing on the virus to others. You need to be sure that the infection stops with you.
-  Secondly, if you are infected with HIV, you certainly do not want your blood to be used in a transfusion in the event you donate blood to someone in need of a blood transfusion. In this sense, it is essential to know if you are infected with HIV, so that your donated blood does not cause someone to contract HIV.

22. What if I do not want to have an HIV test?

Then you really need to play it safe, just as if you know you are HIV-positive. Either choose abstinence and do not have sex with anyone, or practice non-penetrative sex, or use condoms without fail, taking great care to avoid any condom accidents. That way, you will not get any new infections your partners may have, and they will not get yours.

23. I think I know of someone who has HIV or AIDS. What should I do?

Because people with HIV look and feel perfectly healthy for a long time, they can do their job as well as they could before they were infected. They are part of society. Therefore, it is understandable that someone with HIV should want to be treated just like anyone else. Respect that person's privacy and do not spread the word about his or her infection. Remember: you cannot get HIV from "casual contact" with this person.

We all need to learn to live with HIV and AIDS. We all have a responsibility in the AIDS era to talk openly about HIV and to take action to prevent its spread. This includes understanding people with HIV/AIDS and giving them love and support, not prejudice and rejection.

Information obtained from <http://www.unaids.org/hivaidsinfo/faq/effect.html>